DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/18/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING · 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 6300 9TH STREET NW WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG Received 8 10 0000 W one **INITIAL COMMENTS** W 000 An recertification survey was conducted from August 3, 2010, through August 5, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records, including incident reports. W 120 483.410(d)(3) SERVICES PROVIDED WITH W 120 **OUTSIDE SDURCES** Ali staff will be trained on individual #2's IPP goal on attending the day program. The The facility must assure that outside services management team will review IPP meet the needs of each client. documentation weekly and staff will receive ongoing training on documentation for all IPP 8/27/10 goals. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure outside services met the needs of one of three clients in the sample. (Client#2) The findings include: On August 3, 2010 at 12:28 p.m., discussion with the day program case manager and the review of Client #2's attendance records revealed that she had not attended the day program since she was admitted on November 11, 2009. The case manager indicated that when the client rode the van to the day program, she went out to the van and tried various methods to encourage the her to enter the building, however, the client refused to exit the van. According to the case manager, if the client exited the van and entered the day LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE TIME Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 deficiencies are cited, an approved plan of correction are disclosable 14 deficiencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/18/2010 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WNG 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC **6300 STH STREET NW** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (205) COMPLETION DATE TAG TAG DEFICIENCY W 120 Continued From page 1 W 120 program, it would be documented. On August 4, 2010 at 4:00 p.m., the review of the client's IPP revealed a goal which stated that Client #2 "will sttend her day program one day a week with verbal prompts, gestures and reinforcement for three consecutive months. At the time of the survey, however, there was no evidence the day program reinforcement efforts to get the client to enter the day program when she arrived on the van, had been documented. W 124 483.420(a)(2) PROTECTION OF CLIENTS W 124 The QMRP/ Residential Manager will ensure RIGHTS that consent from guardians/ advocates is obtained before any individual receives The facility must ensure the rights of all clients. Therefore the facility must inform each client. sedation or when any issue arises regarding parent (if the client is a minor), or legal guardian, restriction of their rights. The Human Rights of the client's medical condition, developmental Committee will monitor for compliance by and behavioral status, attendant risks of QMRP/ Residential Manager. 8/23/10 treatment, and of the right to rafuse treatment. This STANDARD is not met as evidenced by: Based on Interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of three clients included in the sample. (Client #2) The finding includes: During the entrance conference on August 3, 2010, beginning at approximately 8:30 a.m., the

qualified mental retardation professional (QMRP) and residential manager (RM) indicated that the

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PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 08GD82 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LBC IDENTIFYING INFORMATION) (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 124 Continued From page 2 W 124 Client #2 had sister who assisted with making health care decisions On August 4, 2010, at approximately 12:20 p.m., review of Client #2's medical records revealed a physician's order dated July 2010, for Ativan 2 mg by mouth one hour prior to her dental appointment. Interview with the QMRP on the same day approximately 12:40 p.m. confirmed that the sedation was given on July 6, 2010. Review of Client #2's Psychological Assessment dated October 2010, on August 4, 2010, at approximately 1:20 p.m., revealed the client was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of Client #2's record falled to provide evidence that written informed consent had been obtained for the use of the sedative medication. At approximately 1:35 p.m., the QMRP acknowledged that she had not obtained consent from Client #2's sister prior to the administration of Attvan. W 158 483.420(d)(4) STAFF TREATMENT OF W 156 CLIENTS The serious reportable investigation form will be amended to include a signature line for the 8/23/10 The results of all investigations must be reported administrator. to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident for one of three clients included in the sample. (Client #1)

08-26-2010 PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC 6300 9TH STREET NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) W 158 Continued From page 3 W 156 The finding includes: On August 5, 2010, at approximately 2:20 p.m., interview with the qualified mental retardation professional (QMRP) and review of the facility's Incident report dated June 19, 2010 and corresponding investigative report dated June 20. 2010 revealed Client #1 indicated to the Licensed Practical Nurse (LPN) that she had pain in her abdomen. The LPN immediately notified the Registered Nurse (RN) who instructed the LPN to evaluate Client #1. Upon her evaluation, the LPN determined that Client #1's abdomen was distended and tight. The primary care physician ordered for Client #1 to be transported to the emergency room via the facility's transportation. Client #1 was admitted into the hospital on June 20, 2010 and discharged on June 20, 2010. She was diagnosed with a partial small bowel obstruction. Further review of the corresponding investigative report revealed that the QMRP (Investigator) and Incident Management Coordinator (IMC) completed and signed the investigation on June 29, 2010. However, there was no written evidence that the results of the investigation were reviewed by the administrator within five working days. Interview with the QMRP and Residential Manager on August 5, 2010, at approximately

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investigation.

W 159

2:55 p.m., acknowledged that the administrator

Each client's active treatment program must be

had not signed the final results of the

483.430(a) QUALIFIED MENTAL

RETARDATION PROFESSIONAL

Event ID: UF4811

Facility ID: 09G062

W 159

If continuation sheet Page 4 of 20

PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX MPLETION DATE TAG TAG DEFICIENCY W 159 Continued From page 4 W 159 Integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's qualified mental ratardation professional falled to coordinate, integrate, and monitor services for three of three clients in the sample. (Clients #1, #2, and #3) The finding include: 1. On August 3, 2010, at 8:20 a.m., interview with the direct support staff revealed that the client had been enrolled at a new day program since 2009, however had always refused to enter the bullding. During the entrance conference on August 3, 2010, at 9:37 a.m., the qualified mental retardation professional (QMRP) confirmed the staff statements concerning Client #2's day program attendance. Further discussion with the QMRP revealed that in 2010, the interdisciplinary team had recommended various strategies which had been attempted to encourage the client to attend her day program, however these efforts had been futile. [Cross refer to W120]. Record review on August 3, 2010, at 12:28 p.m., revealed Client #2 was admitted to the day program on November 11. 2009, however had never attended the program. According to the QMRP, since the client's admission to the day program, she had usually refused to leave the group home. Various

strategies had been attempted by group home and the day program staff to encourage the

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	refuse to exit the value program. On August 5, 2020, continued discussion Client #2 revealed the attend her day program. Record review on A revealed the following efforts to address C (1) On January 28, 23 at the group home be psychologist, who he facility's consulting the According to the QN presented his recommendations recomme	however she continues to in upon arrival at the day beginning at 12:39 p.m., in with the QMRP concerning hat due to the client's failure to ram, and the complexity of the r sought the assistance of the effective strategies. ugust 5, 2010 at 12:45 p.m., ing information regarding lient #2's concerns: 2010, Client #2 was assessed by an independent consulting ad been recommended by the behavioral specialist. IRP, the psychologist intendations at a case he group home on March 17, conference notes and excelled the following: ristics of autism." for taking her to the day use, munication strategies. Use what she will be doing seat, day program). d language evaluation with ons.	•		a. The communication book will be re- include pictures that address individual day program attendance and activities the day. QMRP/ Residential Manager monitor implementation of scheduled a	al #2's during will	9/03/10
	QMRP and record re- 7(02-99) Previous Versions O	view revaaled that on June					
	· / LIAMINIA AMMINIS CI	bsolete Funct fir (16464)			L. ID. CROCCO		

PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 159 Continued From page 6 W 159 29, 2010, the speech and language pathologist (SLP) brought Client #2 a picture book and reviewed it with her one on one staff on duty. On August 5, 2010 at 2:02 p.m., the review of the picture book, which was confirmed by the OMRP. revealed that it did not include the recommended pictures of the van, van seat, and the day program, -She should have a pattern that she needs to follow. -Randomly attempt to take her on the van one day a week. [Cross refer to W252], Interview with the QMRP The Behavior Specialist developed a new form on August 5, 2010, at 2:40 p.m., revealed that the that specifically addresses steps that Individual client's tolerance of attempts to take her to the #2 should take to attend her day program, All day program should be documented on the staff will be trained on the new document. 8/27/10 Antecedent Behavior Consequence (ABC) data collection form. The subsequent review of the ABC data collection form revealed that it was not designed to accurately monitor the client's performance in the objective, as written. The review of the client's Individual program plan (IPP) however, revealed an objective had been developed to include seven steps. Although Interview with the QMRP, the home manager, and the client's one on one direct support staff verbalized these steps, consistent program documentation was not available, as evidence of its implementation. An appointment was made for Individual #2 to -Team should reevaluate the use of a helmet. be evalueted by her ophthalmologist for helmet -Set up an appointment with the ophthelmologist use. In the future, the management team will to evaluate the use of the helmet. review all recommendations and address them 9/10/10 in a timely manner. [Cross refer to W282]. On August 5, 2010 at 2; 25 p.m., a discussion with the QMRP revealed the nurse indicated that the use of the protective

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/18/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (25) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY W 159 Continued From page 7 W 159 helmet may have been initially recommended by the ophthalmologist, to prevent self injurious behavior. Further interview with the QMRP, and the subsequent record review on August 5, 2010, at 2:40 p.m., revealed that available records did specify when and why the helmet was initially recommended. The record further revealed that the client's ophthalmology consultation reports dated April 12, 2010 and May 5, 2010, did not include a request for an assessment of the client to determine if the use of a helmet continued to be warranted. b. Interview with the QMRP on August 5, 2010, at b. A copy of the assessment done by the 1:04 p.m., had also revealed that after the case second psychologist was provided by the conference was held on March 17, 2010 for Client Behavior Specialist to the QMRP. 8/25/10 #2, the behavioral specialist recommended a second opinion regarding the "autistic features." According to the QMRP, on May 10, 2010, a second psychologist conducted a behavioral observation of Client #2 for approximately thirty minutes at the group home. The QMRP indicated that the second psychologist concurred with the previous psychologist that the client exhibited "autistic characteristics." Continued discussion with the QMRP, however revealed the report of this observation had not been provided for the client's record. c. Continued interview with the QMRP on August c. An updated Behavior Support Plan and 5, 2010, at 1:11 p.m., revealed that after the psychological assessment was provided by the second psychologist diagnosed that Client #2 exhibited "autistic features", the behavioral Behavior Specialist with the recommended

FORM CMS-2567(02-99) Previous Versions Obsolute

specialist deemed it beneficial to conduct an

updated psychological assessment and an updated behavior support plan. On August 5, 2010, at 3:15 p.m., the record revealed the most current behavior support plan (BSP) was dated October 31, 2009 and the psychological

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updates

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8/26/10

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W 159	assessment was datime of the survey, it psychological assess At the time of the suthat services recommon 17, 2010 cas coordinated timely be ensure their implems. The QMRP failed	thed January 6, 2010. At the the updated BSP and asment had not be provided, sirvey, there was no evidence mended during Client #2's se conference had been by the facility's QMRP, to centation for the client.	W1	2. Cross reference W242		Sinish
	Individual program pactivities of dental has activities of dental has a common training objectives for W249.1) 4. The QMRP failed treatment for the imidentified in Client #1	ian (IPP) included training in		3. Cross reference W249.1 4. Cross reference W249.2		8/9/1D 8/30/10
W 242	483.440(c)(6)(iii) IND The Individual prograthose clients who lac skills essential for pri (Including, but not lim personal hyglene, de bathing, dressing, gra of basic needs), until that the client is devel acquiring them.	pividual program plan must include, for the include inclu	W 24			
PM CHE 244	Based on observation	n, staff interview and record	·			

PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PRDVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION (X9) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X5) COMPLETION PREFIX TAG TAG DATE DEFICIENCY W 242 Continued From page 9 W 242 review, the facility falled to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for one of the three clients in the sample. (Client #1) An IPP goal was put in place for Individual #1 The finding includes: to be encouraged to brush her teeth twice daily. Review of Client #1's medical record on August 4. The QMRP will monitor all recommendations 2010, at approximately 9:10 e.m., revealed a from Medical Consultants to ensure that they dental consultation dated July 19, 2010, that are edressed appropriately and in a timely recommended the client brush her teeth two (2) manner. 8/9/10 times a day. Continued review of the client's record revealed the client had full mouth scaling and prophylaxis completed during the dental appointment Review of Client #1's Individual Program Plan (IPP) dated August 2010, at approximately 9:12 a.m., revealed no evidence of a training program to address the client's oral hygiene. Review of the qualified mental retardation professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximately 9:15 a.m., revealed Client #1's tooth brushing program was being implemented twice dally. During Interview with the QMRP on August 4. 2010, at approximately 9:20 a.m.; however, revealed that Client #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the client's IPP included training in activities of dental

483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan,

hygiene.

W 249

W 249

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06:46:00 a.m.

		AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM): 08/18/2010 MAPPROVED): 0938-0391
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W 249	approximately 8:30 to document at leas (M-W-F) if the client following steps durit administration. Furt medication program a. Wash hands; b. Pour water in cup administration; c. Punch out medica. Proper disposal oe. Instill eye drops a f. Put cup in kitcher medications	a.m., revealed that staff was It three times per week It was able to perform the Ing the medication Inher review revealed the self- In was as follows: In provided for medication Interest medication cup; Ind In sink after taking all Ince that the client wes given Illy participate in the self-	w:	249			
	on August 4, 2010, a crushed and mixed (applesauce than spondications to Clien revealed the RN pout #2 who then was able consume the content During a face-to-face August 4, 2010, at a revealed Client #2 he however, the programe vening.	a administration observation at 7:55 a.m., revealed RN #1 Client #2's medication in con-fed the cup of t #2. Further observation ared a cup of water for Client to pick up the cup and ts with one (1) verbal prompt. Interview with RN #1 on pproximately 7:31 a.m., and a self-medication program on was implemented in the		partio Prog	divduals will be given the opportuctipate in the Medication Administram. Nursing staff will be instructive steps in the self-medication pro	ration ed to	8/30/10
1	approximately 8:35 a	on August 4, 2010, at .m., revealed that staff was			,	ĺ	

06:46:16 a.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	PROVIDER OR SUPPLIER NITY MULTI SERVICE	28, INC		6300	TADDRESS, CITY, STATE, ZIP COD 9TH STREET NW BHINGTON, DC 20011		
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	to document at least (M-W-F) if the clien following steps during administration. Furt medication program a. Wash hands; b. Pour water in curadministration; c. Punch out medication e. Put cups in kitches medications There was no evides the opportunity to furmedications There was no evides the opportunity to furmedication program 3. During medication on August 4, 2010, a punched out all of Capunched out	the three times per week th was able to perform the ing the medication her review revealed the self- in was as follows: provided for medication ations from blister pack; with applesauce; in sink after taking all ince that the client was given lity participate in the self- in administration observation at 7:35 a.m., revealed RN #1 lient #3's medications from RN placed the cup of ent #3's hands in order for the e medications with one (1) ther observation revealed the water for Client #3 who then he cup and consume the	W2	3. A	Il steps within the self-medicati be followed by the individuals v stance from nursing staff.	on program with the	8/30/10
RM CMS-256	(02-09) Previous Versions (Seciela Fuent 27-11E4D44					

PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X5) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 8. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) W 249 Continued From page 13 W 249 to document at least three times per week (M-W-F) if the client was able to perform the following steps during the medication administration. Further review revealed the selfmedication program was as follows: a. Wash hands: b. Pour water in cup provided for medication edministration: c. Punch out medications from blister pack; d. Proper disposal of used medication cup: f. Put cup in kitchen sink after taking ali medications There was no evidence that the client was given the opportunity to fully participate in the self-medication program. 4. The facility failed to consistently implement 4. The staff will be trained to encourage strategies identified in Client #1's IPP designed to Individual #1 to wear her hearing aids during Increase tolerance of her hearing aid during waking hours. In the future, the management waking hours, as evidenced below: team will frequently check the usage of individual #1's hearing aids and the staff will On August 3, 2010, at 10:48 a.m., observation at 9/10/10 recieve on-going training. the day program revealed Client #1 walked over to the desk where the surveyor was sitting with the day program specialist. The program specialist signed the word [wave] and the client responding by waving [hi] to the surveyor. The day progrem specialist signed [thank you] and Client #1 responded by signing thank you back. At 4:07 p.m., evening observations at the home revealed direct care staff #1 signed the word [pretty] to Client #1 and she responded by signing

bathroom to wash her hands.

the word pretty back to staff. At approximately 4:10 p.m., the house menager was observed to sign the word [wash hands] to Client #1 during snack time. Client #1 immediately want to the

PRINTED: 08/18/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G082 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PRÉFIX PREFIX TAG TAG DEFICIENCY) W 249 Continued From page 14 W 249 On August 3, 2010, at approximately 5:15 p.m., interview with direct care staff #1 revealed that she signed to Client #1 because she was deaf. Further interview revealed that Client #1 had a hearing aid to assist her with hearing. This was also acknowledged through interview with the House Manager on August 4, 2010, at approximately 11:30 a.m. On August 4, 2010, at approximately 9:50 a.m., review of Client #1's current physician orders dated July 2010 revealed the client had a diagnosis of bilateral hearing loss. Interview with the qualified mental retardation professional (QMRP) and review of Client #1's individual Support Plan (iSP) dated January 4, 2010 on the same day at approximately 12:15 p.m., revealed an objective for the client to tolerate her hearing aid during waking hours 100% of trials daily. Observations the previous day (August 3, 2010). however, revealed that Client #1 was not observed wearing her hearing aid at the day program and at her home. W 252 483.440(e)(1) PROGRAM DOCUMENTATION W 252 Cross reference W120 8/27/10 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on an individual

Program Plan (IPP) objective, for one of three

PRINTED: 08/18/2010 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BURLDING B. WING 09G062 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ıĐ (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 252 Continued From page 15 W 252 clients in the sample. (Client #2) The finding include: [Cross refer to W120]. The facility failed to ensure that data was consistently maintained on the training objective designed to increase Client #2's day program attendance, as evidenced below. Interview with the home manager and the qualified mental retardation professional (QMRP) on August 3, 2010 during the entrance conference at 9:30 a.m., revealed Client #2 had been refusing to attend her day program for sometime. Further discussion with the QMRP, home manager, and one on one support staff indicated that if the client went to the day program, she refused to get off the van. interview with both the QMRP and the home manager revealed that a training objective had been developed to monitor the client's progress on attending the day program. The home manager indicated that staff had been practicing the steps of the training objectives to encourage the client to attend her day program. According to staff. attempts were made to implement the steps of the objective, however, the client was usually non-compliant. On August 4, 2010 at 4:00 p.m., the raview of the client's IPP revealed a goal which stated that she "will attend her day progrem one day a week with verbai prompts, gestures and reinforcement for

practice" the steps:

three consecutive months. The review of the in home objective revealed the client "will be encouraged by her one on one to attend her day program at least one day a week. "She will

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PRINTED: 08/18/2010 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies OF Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL	TIPLE CONSTRUCTION	(X3) DATE 8 COMPLI	
					-	
		09G062	B. WING		08/0	5/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE			REET ADDRESS, CITY, STATE, ZII 6300 9TH STREET MW WASHINGTON, DC 20011	PCODE	
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
	(1) Put on coat and (2) Get back pack ff (3) Walk to the back do (5) Walk to the back do (5) Walk to the van (6) Get on the van (7) Get off the van a con August 5, 2010 revealed data collect May 25, June 22, at the time of the st data on Client #2's increase her day procllected at the frequencial monitor her progres 483.440(f)(3)(i) PRCCHANGE The committee short monitor individual prinappropriate behaving the opinion of the client protection and This STANDARD is Based on staff interfacility's Human Rigreview and approve measures, for one of sample. (Client #2) The finding includes On August 3, 2010, to 5:10 p.m., revealed	jacket rom closet k door or closet k door or at the day program at 1:37 p.m., record review ction on the practice steps on and August 3, 2010. Invey, there was no evidence training objective designed to ogram attendance, had been usency required to accurately is. DGRAM MONITORING & uid review, approve, and rograms designed to managerior and other programs that, committee, involve risks to it rights. In not met as evidenced by: view and record review, the his Committee (HRC) falled to the use of restrictive of the three clients in the conservations from 11:58 a.m. and Cilent #2 was observed to net two times at (4:10 p.m.	W 262		e at the next uture, all restrictive	9/7/10

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	APPROVED
<u>OMB NO.</u>	0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		PLE CONSTRUCTION G	(X3) DATE COMP	
		09 G062	B. Wi	NG		08/	05/2010
_	PROVIDER OR SUPPLIER NITY MULTI SERVICE			6:	REET ADDRESS, CITY, STATE, ZIP CODE 300 9TH STREET NW VASHINGTON, DC 20011	, , , , , ,	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	•	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	NJI D BE	COMPLETION DATE
W 262	and 4:42 p.m.). Interview with the faretardation profession 2010 at 2:27 p.m., in helmet was prescribine client's right eye QMRP, her discussionad revealed that the had been initially recophthalmologist. Review of the current July 2010 on August 10:00 a.m., revealed	collity's qualified mental conal (QMRP) on August 5, evealed that the protective led by the eye doctor due to blindness. According to the ion with the nurse in the past e use of the protective helmet	W	262			
W 331	review of the facility's (HRC) minutes from 2010, revealed that (and/or discussed the helmet. This was ac interview with the Hoday at approximately 483.460(c) NURSING The facility must proservices in accordan This STANDARD is Based on observation review, the facility's n	nuse Manager on the same 23:45 p.m. 3 SERVICES Vide clients with nursing ce with their needs. not met as evidenced by: n, interview and record lursing services falled to as as prescribed for one of	W 3	31			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	LTIPLE CONSTRUCTION	(X3) DATE COMPI	
		0 9 G062	B. WING		08/	05/2010
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	es, INC	s	TREET ADDRESS, CITY, STATE, ZIP CO 8300 9TH STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
W 331	observed to receive 1 capsule. During the realstive to having a the nurse. With endicient was able to repressure (BP) assessore (BP) assessor	at 7:35 a.m., Client #3 was be Hydrochlorothiazide 12.5 mg, his time, the client was initially her blood pressure taken by couragement, however, the emain still for her blood essment. at 7:39 a.m., interview with eming the medication revealed emittent refusal and/or failure cod pressure assessment had cribed a Clonidine Patch, 6.3 or an area on her body once a tha nurse indicated that the ure be monitored twice a day. View of the client's record at dithe physician's orders for the odication. A physician's order 0, prescribed that Client #3's assessed and documented at 11:42 a.m., record review pressure was documented for the scheduled times in May previous interview with the 1 that the client sometimes and/or refused, there was no my the client's blood essessed and/or documanted, and 13, 2010) of the six 10 MAR revealed a similar g BP readings on seven days 3, 23 and 24, 2010).	W 33	The nursing staff received add on documenting on medication record on 8/19/10. In the futur nurse will review medical record consistent and proper docume assessments. The Director of I review medical and nursing se provided on time.	administration a, the primary ds to ensure ntation for BP Nursing will onthly basis to	B/19/10

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION IS	(X3) DATE (SURVEY ETED
		09G082	B, Wi	NG_		080	05/2010
COMMU	PROVIDER OR SUPPLIER NITY MULTI SERVICE			6	REET ADDRESS, CITY, STATE, ZIP CODE 300 9TH STREET NW VASHINGTON, DC 20011		
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN DF CORRECT (EACH CORRECTIVE ACTION SHOUNDS REFERENCED TO THE APPROPRICIENCY)	N D RE	COMPLETION DATE
W 331	At the time of the sunursing services had documentation of C	urvey, there was no evidence dimaintained consistent lient #3's evening blood o ensure accurate monitoring		3331	DEFICIENCY		

STATEMEN AND PLANT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION ING	(XS) DATE S COMPL	SURVEY ETED 05/2010
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 00/1	1012010
COMMU	NITY MULTI SERVICE	EB, INC		STREET NETON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FILL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLET DATE
1 000	INITIAL COMMEN	rs		1000			
	2010 through Augu of three residents wo faix females with retardation and disatrant findings of the observations at the programs, interview	survey were based o group home and thre is with residents and and administrative:	n sample copulation ital n se day staff, and				
<u> </u>	•	MS AND BATHROO		1 075	Night stands will be purchase #, #3, and #6.	d for individuals	
	Each bedroom shall following items for e	l be equipped with at each resident	least the		#, #3, BNC #0.		9/10/10
	(d) Night stand,			į			
	Based on observation failed to ensure that with a night stand for	met as evidenced by: on and interview, the each bedroom was o reach resident for th lent's #1, #3, and #6)	GHMRP equipped ree of				
-	The finding includes	:		,			
	August 5, 2010, begi bedrooms of residen observed to have no individuals. In an inte house manager (HM	erview at the same tire) acknowledged that been provided for the	the e ne, the the				
	At the time of the sur	vey, there was no ev	idence				

STATE FORM

UF4B11

8/26/10 If continuation shadt 1 of 18

	T OF DEFICIENCIES OF CORRECTION	(XII PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0083		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE (COMPL	ETED
AME OF P			OTREET AN	DRESS OFFICE	STATE, ZIP CODE	08/	35/2010
	DAMENTY MIN THE PRICES INC. 6300 91		6300 9TH	STREET NY STON, DC 20	V		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XII) COMPLETE DATE
1075	Continued From pa	age 1		1 075			
	that each bedroom minimum required	n had been equipped v items.	vith the	٠			
1 090	3504.1 HOUSEKE	EPING		i 090			
	maintained in a sat and sanitary manno	terior of each GHMRF ie, clean, orderly, attra er and be free of lirt, rubbish, and objec	ictiva,			·	
	Based on observati Home for the Menti (GHMRP) failed to GHMRP was maint attractive manner fo	met as avidenced by: ion and interview, the elly Retarded Persons ensure the exterior of bined in a safe, order or six of six residents #1, #2, #3, #4, #5 and	Group the y, and in the		,		
	The findings include	e:					
	on August 5, 2010, 11:00 a.m. During ti	e environment was co beginning at approxin he inspection, the sur by the House Manager were identified:	nately vevor				
	Exterior:						
	 The front porch the home evidenced 	baseboard on the left : i mildew.	side of		. Mildew was removed from the k	oft side of	8/6/10
2	2. The front drivews reating a potential	ey had an elevated and trip hazard.	92,	2	. Front driveway will be repaired.		9/10/10
l v	i. On the upper rear vail, there was a not he exterior wall una	right side of the exte ticeable hole which ma ttractive.	rior akes	3.	. The holes will be repaired on the	right side	9/10/10

Health F	Requiation Administra	ation				FORM	MAPPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MUL A. BUILD B. WING		(X3) DATE COMPL	SURVEY LETED
NAME OF F	PROVIDER OR SUPPLIER	HFD03-0083	OTREET AD	ODDERD ACT		<u>08/</u>	05/2010
	NITY MULTI SERVICE	is, inc	6300 STH	I STREET I STON, DC			
(X4) ID PREFIX TAG	i (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FILL	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ACH III DI RIE	(X5) COMPLETE DATE
1 090	Continued From page 2		1 090				
	 4. On the upper rear left side of the exterior wall there were unsightly rust spots. 5. The rear fire escape steps evidenced chipping and peeling paint on the tread. 6. The rear basement steps evidenced crumbling and broken cement on the tread which could be a potential trip hazard. 		·	The rust will be removed on rea home.	r left side of	9/10/10	
				5. The rear fire escape will be pain	ited.	9/10/10	
				6. The steps will be repaired leading basement.	ig to tha	9/10/10	
	Interior:						
Ì	The basement carps	et has noticeable ata	ins.	•	Carpet will be removed and floor wi	il be tiled.	9/10/10
	The House Manage August 5, 2010 at 12	er confirmed the findl 2:00 p.m.	ngs on				0.10,10
l 180	3508,1 ADMINISTRA	ATIVE SUPPORT		I 180			
	Each GHMRP shall administrative suppo needs of the residen Habilitation plans.	ort to efficiently meet	the Ir				
	This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's qualified mental retardation professional failed to coordinate, integrete, and monitor services for one of three residents in the sample. (Resident #2) The finding includes:						
			. [
) t	On August 3, 2010 at the direct support sta the resident had been program since 2009, o entar the building.	ff at this time reveals renrolled at a new d	ed that	,			
	During the entrance conference on August 3,		t 3.	.		}	- 1
alth Deardes	nn Administration					i	

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STATEMEI AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	(X2) MULTIPLE CONSTRUCTION A. BUILDING		SURVEY LETED	
		HFD03-0083		B. WING		00/	05/2040	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DDRESS, CITY, STATE, ZIP CODE				
СОММИ	NITY MULTI SERVICE	·	WASHING	H STREET NW IGTON, DC 20011				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
i 180	Continued From pa	ge 3		i 180				
	2010 at 9:37 a.m., the qualified mental retardation professional (QMRP) confirmed the staff statements concerning Resident #2's day program attendance. Further discussion with the QMRP revealed that in 2010, the interdisciplinary team had recommended various strategies which had been attempted to encourage the resident to attend her day program, however these efforts had been futile.							
	[Cross refer to W120]. Record review on August 3, 2010 at 12:28 p.m., revealed Resident #2 was admitted to the day program on November 11, 2009, however had never attended the program. According to the QMRP, since the resident's admission to the day program, she had usually refused to leave the group home. Although various strategies had been attempted by group home and the day program staff to encourage the resident, if the resident rode on the van, she refused to exit the van upon arrival at the day program.							
	On August 5, 2020, beginning at 12:39 p.m., continued discussion with the QMRP concerning Resident #2 revealed that due to the resident's failure to attend her day program, and the complexity of the situation, she further sought the assistance of the IDT to identify more effective strategies.							
	Record review on August 5, 2010, at 12:45 p.m., revealed the following Information regarding efforts to address Resident #2's concerns:		ng					
	(1) On January 28, 2010, Resident #2 was assessed at the group home by an independent consulting psychologist, who had been the recommended by the GHMRP's consulting behavioral specialist. According to the QMRP, regulation Administration							

STATEMEN AND PLAN	FATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILD		(X3) DATE SURVEY COMPLETED	
		HFD03-0083		B. WING		OR.	05/2010
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 40	USIZUTU
COMMU	NITY MULTI SERVICE	8, INC	6300 9TH WASHING	STREET N TON, DC			
(X4) IC PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	E 1111	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SIN CROSS-REFERENCED TO THE APP DEFICIENCY)	MII D RE	(X8) COMPLETE DATE
l 180	Continued From page 4			1 180			
	the psychologist presented his recommendations at a case conference held at the group home on March 17, 2010. Review of the case conference notes and recommendations revealed thay included the following:						
	a. "Exhibits characteristics of autism." - Develop a program for taking her to the day program. Make it visual. - Explore visual communication strategies, use pictures to show her what she will be doing (picture of van, van seat, day program). -Possible speech and language evaluation with			Cross reference W159		9/03/10	
	On August 5, 2010 at the QMRP and recourse 29, 2010, the apathologist (SLP) be book and reviewed it duty. On August 5, 2 of the picture book, a QMRP, revealed that	gust 5, 2010 at 1:55 p.m., interview with IRP and record review revealed that on 19, 2010, the speech and language ogist (SLP) brought Resident #2 a picture and reviewed it with her one on one staff on 20 August 5, 2010, at 2:02 p.m., the review picture book, which was confirmed by the 1, revealed that it did not include the mended pictures of the van, van seat, and					- ·
	-She should have a pattern that she needs to follow Randomly take attempt to take her on the van one day a week.				Cross reference W159		9/03/10
	[Cross refer to W252 on August 5, 2010, a resident's tolerance of day program should data collection form. The abc data collection to the designed to acculton Administration	t 2:40 p.m. revealed of attempts to take he be documented on the The subsequent revi on form revealed that	that the er to the ne abc ew of it was			. i	

09-01-2010

AND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	UMBER: A. BUILD!			(X3) DATE SURVEY COMPLETED	
		HFD03-0083		B. WING		08/0	5/2010
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE	s, inc	6300 9TH WASHING	STREET N TON, DC			
(X4) IID PRÉFIX TAG	REGULATORY OR LISC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETE DATE
1 180	Continued From pa	ge 5		l 180			
	review of the reside (IPP) however, reve plan (IPP) objective included seven step QMRP, the home m one on one direct st steps, consistent pr	objective, as written. ont's individual progra- paled an individual pro- had been developed s. Aithough Interview nanager, and the resi upport staff verbalize ogram documentation ce of its implementa	am plan rogram d and v with the ident's ed these				
	-Team should reevaluate the use of a heimetSet up an appointment with the ophthalmologist to evaluate the use of the heimet.		mologist		Cross reference W159(a)		9/03/10
	25 p.m., interview w was thought that Rebeen Initially recommontal phthalmologist, to behavior. Further inthe subsequent recat 2:40 p.m., reveals specify when and w recommended. The	prevent self injurious terview with the QMF and review on Augusted that available reconstruction from the helmet was in record further reveal almology consultation and May 5, 2010, dir an assessment of the if the use of a helmet.	ted that it hay have and to 5, 2010 ords did itially led that it reports id not he				·
	b. Interview with the 1:04 p.m. had also n conference was held Resident #2, the beharcommended a ser "autistic features." A May 10, 2010, a sec a behavioral observa approximately thirty to The QMRP indicated the conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the conference was held to be a conference with the co	evealed that after the I on March 17, 2010 lavioral specialist cond opinion regardi ccording to the QMF ond psychologist cor lition of Resident #2 or minutes at the group	e case for ng the RP, on nducted for		Cross reference W159(b)		8/25/10

STATEMEN AND PLAN I	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILD		(X3) DATE (COMPL	
		HFD03-0083		B. WING		08/8	05/2010
NAME OF P	ROVIDER OR SUPPLIER		1		, STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE		HTR DOEB WASHING	STREET N TON, DC	IW 20011		
(XA) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FIRE	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD RE	(005) COMPLETE DATE
	psychologist that the characteristics." Co QMRP, however recobservation had be record. c. Continued intervicts, 2010 at 1:11 p.m. second psychologis exhibited "autistic feapedailist deemed it updated psychological develop an updated August 5, 2010 at 3 the most current be was dated October assessment was datime of the survey, the psychological assess for review and approximations."	ge 6 rrad with the previous e resident exhibited intinued discussion was vealed the report of the provided for the new with the QMRP of the provided for the new with the QMRP of the provided for the new with the QMRP of the provided for the new with the QMRP of the diagnosed Resident attrest, the behavior of the the provided is the provided part of the provided part of the provided prov	"autistic vith the this esident's In August the at #2 vital ct an to sn. On revealed (BSP) hological At tha	(180	Cross reference W159(c)		8/26/10
i 401	that services recoming March 17, 2010 casi coordinated timely be ensure their implementations of the professional service and evaluation, includevelopmental levels services, and services, and services.	time of the survey, there was no evidence ervices recommended during Resident #2's 17, 2010 case conference had been inated timely by the GHMRP's QMRP, to a their implementation for the resident. 3 PROFESSION SERVICES: GENERAL IISIONS ISIONS I			Cross reference W331		8/19/10
	This Statute is not not on Administration	net as evidenced by:	***				

AND PLAN			er/Clia Imber:	(X2) MULTE A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE: COMPL	BURVEY LETED
NAME OF			STREET AND	PERR CITY I	TATE VID GOOD	08/	05/2010
			6300 9TH	STREET NY TON, DC 20	V		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FILL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETI DATE
	review, the GHMRF ensure health service three residents in the The finding includes On August 3, 2010 to be a color observed to receive	ion, interview and recession, interview and recession as prescribed for the sample. (Resident as: at 7:35 a.m., Resident as: at 7:35 a.m., Resident as: at 7:35 a.m., Resident was the resident was the resident was the remain still for her beament. at 7:39 a.m., Interviewing the medication maternation and anongoing concest resident was prescribed to week. Additionally, the mery care physician as ident's blood pressey. The subsequent mat 8:37 a.m. confirm at 8:37 a.	alled to rone of #3) at #3 was 12.5 mg, initially ken by er, the slood w with evealed d/or m. The ribed a an area e nurse (PCP) sure be eview of ed the il 10, d	I 401	DEFICIENCY		
l r	daily. On August 4, 2010 at evealed no blood pre Resident #3's at six o May 2010. Although t	988UFE was document of the scheduled time	ited for				

06:47:53 a.m. 09-01-2010

PRINTED: 08/18/2010 FORM APPROVED Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING		1		
-		HFD03-0083				08/0	05/2010	
NAME OF P	ROVIDER OR BUPPLIER				STATE, ZIP CODE			
COMMU	NITY MULTI SERVICE	3, INC		9TH STREET NW HINGTON, DC 20011				
(X4) ID PREFIX TAG	X EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
1401	Continued From pa	ge 8		I 401				
	and/or documented 2010) of the six da revealed a similar fi readings on six day 24, 2010). At the time of the si	Issure was not assest on three (May 10, 7 tes. The June 2010 I inding of no evening s (June 2, 7, 15,16,1	, and 13, MAR BP 8, 23 and					
	nursing services had maintained consistent documentation of Resident #3's evening blood pressure readings to ensure accurate monitoring of the effectiveness of her prescribed medications.							
l 422	3521.3 HABILITATI	ON ANO TRAINING		1 422	Cross reference W249(2)		8/30/10	
	and assistance to re	provida habilitation, esidents in accordan vidual Habilitation Pla	ce with					
	Based on observation review, the GHMRP professional (QMR) received continuous	met as evidenced by on, staff interview and 's qualified mental resonance resonance resonance, for active treatment, for included in the samplind #3)	d record standation sident's r three of			,		
	The findings include	r				,		
-	on August 4, 2010, Registered Nurse # Resident #1's medic The RN placed the of Resident #1's hands consuma the medic prompt. Further obs- poured a cup of water	n administration obset at 7:25 a.m., reveale I (RN #1) punched o eations from the bliste cup of medications in in order for the resid ations with one (1) pre- ervation revealed the er for Resident #1 with the cup and consume	ut all of er pack. ito dent to tysical RN					

STATE FORM

Health F	Requiation Administra	ation ·	_		<u></u>	ron	M APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0083		(X2) MUL A. BUILD B. WING			LETED
NAME OF B	ROVIDER OR SUPPLIER	111100-000	STREET AN	DOESE CITY	, STATE, ZIP CODE		<u> 105/2010</u>
1	NITY MULTI SERVICE	:8, INC	6300 9TH	STREET I	w		
(X4) ID PREFIX TAG				PREFIX TAG	PROVIDER'S PLAN (EACH GORRECTIVE, CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
1422	Continued From pa	ge 9		1422			
	contents with two (2	2) verbal prompts.					
	During a face-to-face interview with RN #1 on August 4, 2010, at approximately 7:30 a.m., revealed Resident #1 had a self-medication program however, the program was implemented in the evening. Review of Rresident #1's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:30 a.m., revealed that staff was to document at least three times per week (M-W-F) if the resident was able to perform the following steps during the medication administration. Further review revealed the self-medication program was as follows:						
	a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from bilister pack; d. Proper disposal of used medication cup; e. Instill eye drops and f. Put cup in kitchen sink after taking all medications There was no evidence that the resident was given the opportunity to fully participate in the self- medication program.						
	2. During medication edministration observation on August 4, 2010, at 7:55 a.m., revealed RN #1 crushed and mixed Resident #2's medication in applesauce than spoon-fed the cup of medications to resident #2. Further observation revealed the RN poured a cup of water for Resident #2 who then was able to pick up the cup and consume the contents with one (1) verbal prompt.						

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0083 08/05/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1422 Continued From page 10 1422 During a face-to-face interview with RN #1 on August 4, 2010, at approximately 7:31 a.m., revealed Resident #2 had a self-medication program however, the program was implemented in the evening. Review of Resident #2's self-medication program dated August, 2010, on August 4, 2010, at approximately 8:35 a.m., revealed that staff was to document at least three times per week (M-W-F) if the resident was able to perform the following steps during the medication administration. Further review revealed the selfmedication program was as follows: a. Wash hands; b. Pour water in cup provided for medication administration; c. Punch out medications from bilster pack; d. Take medication with applesauce: e. Put cups in kitchen sink after taking all medications There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 3. During medication administration observation on August 4, 2010, at 7:35 a.m., revealed RN #1 punched out all of Resident #3's medications from the blister pack. The RN placed the cup of medications into Resident #3's hands in order for the resident to consume the medications with one (1) physical prompt. Further observation revealed the RN poured a cup of water for Resident #3 who then was able to pick up the cup and consume the contents with two (2) verbal prompts. Health Regulation Administration

Health F	Regulation Administr	ation			•	FURI	M APPROVED
STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER'S IDENTIFICAT HEDO3-0		ER/GLIA MBER:	(X2) MULTI A. BUILDIN B. WING _	IPLE CONSTRUCTION		LETED
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DBESS CITY	STATE, ZIP CODE	08/	05/2010
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	During a face-to-face August 4, 2010, at revealed Resident a program however, the in the evening. Review of Resident dated August, 2010 approximately 8:45, to document at least (M-W-F) if the resid following steps during administration. Furtimedication program a. Wash hands; b. Pour water in cup administration; c. Punch out medications d. Proper disposal of Put cup in kitchen medications There was no evider given the opportunity self-medication program. 4. The GHMRP faile stratetgies identified designed to increase during waking hours. On August 3, 2010, at the day progrem reversell.	ce interview with RN approximately 7:40 a sproximately 7:40 a state program was imposed in a self-medication and a self-medication are review revealed to was as follows: a provided for medication are review revealed to was as follows: a provided for medication are review revealed to was as follows: a provided for medication are review revealed to was as follows: a provided for medication are review revealed in a self-medication are taking all and to consistently imposing resident #1's iPP a tolerance of her her as evidenced below at 10:48 a.m., observed at	a.m., tion lemented program at taff was ek orm the the self- tion ck; ip; was ation at alked	1 422	Cross reference W249.4		9/10/10
, i	over to the desk whe with the day program specialist signed the esponding by waving	ere the surveyor was a specialist. The property word [wave] and the g [hi] to the surveyor, at signed thank you a	sitting)ram resident The				

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	TATEMENT OF OEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	A. BUILI		(X3) DATE	SURVEY PLETED	
		HFD03-0083		B. WING	/05/2010			
NAME OF	PROMDER OR SUPPLIER		STREET ADD	RESS, CIT	Y, STATE, ZIP CODE		109/2010	
COMMU	NITY MULTI SERVICE	s, inc	6300 9TH Washing	STREET NW STON, DC 20011				
(X4) 10 PREFUX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
l 422	Continued From page	ge 12		l 422				
	back. At 4:07 p.m.,	etty back to staff. At p.m., the house men word wash hands to snack time. Residen	s at the ed the onded by ager was					
	On August 3, 2010, at approximately 5:15 p.m., interview with direct care Staff #1 revealed that she signed to Resident #1 because she was deaf. Further interview revealed that Resident #1 had a hearing aid to assist her with hearing. This was also acknowledged through interview with the House Manager on August 4, 2010, at approximately 11:30 a.m. On August 4, 2010, at approximately 9:50 a.m., review of Resident #1's current physician's orders dated July 2010 revealed the resident had a diagnosis of bilateral hearing loss. Interview with the qualified mental retardation professional (QMRP) and review of Resident #1's Individual Support Plan (ISP) dated January 4, 2010 on the same day at approximately 12:15 p.m., revealed an objective for the resident to tolerate her hearing aid during waking hours 100% of trials daily. Observations the previous day (August 3, 2010), however, revealed that Resident #1 was not observed wearing her hearing aid at the day program and at her home.		ed that was sident #1 ng. This					
			ot .					
	At the time of the survey, there was no evidence that staff implemented Resident #1's program objective (will tolerate her hearing aid) as							

STATEMENT OF DEFICIACIES NON PLAN OF CORRECTION (CA) DATE SURVEY COMPLETED (CA) DEPOS OF PROVIDER OR SUPPLER COMMUNITY MULTI SERVICES, INC STREET ADDRESS, CITY, STATE, ZIP CODE S300 STH STREET NW WASHINGTON, DC 20011 (CA) DO	1	Health F	Regulation Administra	ation				FORM	APPROVED
MANE OF PROMORER OR SUPPLIER COMMUNITY MULTI SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (CA) IO SUMMARY STATEMENT OF DEFICIENCIES (CA) IO SUMMARY STATEMENT OF DEFICIENCIES (CA) IO		STATEMEN AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILI	DING			
COMMUNITY MULTI SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES PRESSION (ACH DEPOCRACY MUST BE PRECEDED BY PULL PRESSION (ACH DEPOCRACY MUST BE PRECEDED BY PULL TAX (ACH DEPOCRACY MUST BE PRECEDED BY PULL TAX SUMMARY STATEMENT OF DEFICIENCIES PRESSION (ACH DEPOCRACY MUST BE PRECEDED BY PULL TAX 1422 Continued From page 13 required. 1422 Continued From page 13 The habilitation and training of residents by the GHMRR shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute Is not met as evidenced by. Based on observation, staff interview and record review, the facility falled to ensure sean client's individual program plan (IPP) included training in a civities of dental hygiene, for two of the three residents in the sample. (Realdents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of that resident's record revealed the resident and full mouth scaling and prophysics completed during the dental appointment. Review of Resident #1's individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the residents or all hygiene. Review of the Qualified Mental Retardation Professionaria (GMRP's) progress notes dated May 2010, on August 4, 2010, the approximately 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.	i	NAME OF F	ROVIDER OR SUPPLIER	111224444	STREET AL	DRESS CIT	ATATE ZIR CODE	08/	05/2010
PREFIX TAG TAG TAG TAG TAG TAG TAG TAG				es, INC	6300 STH	STREET	NW		
required. 1 432 3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampeoing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each cleant's individual program plan (IPP) included training in activities of dental hygiene, for two of the three residents in the sample. (Residents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of that resident's record revealed the resident had full mouth scaling and prophylaxis completed during the dental appointment. Review of Resident #1's individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiens. Raview of the Qualified Mental Retardation Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.		PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	ELU 1	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		(X5) COMPLETE DATE
The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility falled to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for two of the three residents in the sample. (Residents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of the resident brush teeth two (2) times a day. Continued review of the resident had full mouth scaling and prophytexis completed during the dental appointment. Review of Resident #1's individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the residents or on hygiene. Review of the Qualified Mental Retstratation Professionals (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:16 a.m., revealed Resident #1's tooth brushing program was being implemented.		l 422	1		1 422				
(c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility falled to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for two of the three residents in the sample. (Residents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of the resident's record revealed the resident had full mouth scaling and prophylaxis completed during the dental appointment. Review of Resident #1's individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiene. Review of the Qualified Mental Retardation Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximately 9:16 a.m., revealed Resident #1's tooth brushing program was being implemented.		l 432	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not		l 432	Cross reference W242		8/9/10	
Based on observation, staff interview and record review, the facility falled to ensure each client's Individual program plan (IPP) included training in activities of dental hygiene, for two of the three residents in the sample. (Residents #1 and #3) The finding includes: Review of Resident #1's medical record on August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of tha resident's record revealed the resident had full mouth scaling and prophytaxis completed during the dental appointment. Review of Resident #1's individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiene. Review of the Qualified Mental Retardation Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.			(c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual		bathing, s				
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August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of tha resident's record revealed the resident had full mouth scaling and prophylaxis completed during the dental appointment. Review of Resident #1's Individual Program Plan (IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiene. Review of the Qualified Mental Retardation Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.		J	The finding includes:						
(IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program to address the resident's oral hygiene. Review of the Qualified Mental Retardation Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximately 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.			August 4, 2010, at approximately 9:10 a.m., revealed a dental consultation dated July 19, 2010, that recommended the resident brush teeth two (2) times a day. Continued review of the resident's record revealed the resident had full mouth scaling and prophylaxis completed during		n., 19, sh teeth tha d fuil				
Professional's (QMRP's) progress notes dated May 2010, on August 4, 2010, at approximataly 9:15 a.m., revealed Resident #1's tooth brushing program was being implemented.		((IPP) dated August 2010 at approximately 9:12 a.m. revealed no evidence of a training program		P-12	ļ			
		F N 9 P	'rofessional's (QMRF flay 2010, on August :15 a.m., revealed R rogram was being in	o's) progress notes o 4, 2010, at approximesident #1's tooth bro	dated				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE (COMPL		
HFD03		HFD03-0083		B. WING		08/08/2040		
NAME OF PROVIDER OR SUPPLIER STREET A			STREET AL	08/05/2010 DDRESS, CITY, STATE, ZIP CODE				
COMMU	NITY MULTI SERVICE	EB, INC		i STREET I STON, DC				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	(CB) COMPLETE DATE		
l 432	Interview with the QMRP on August 4, 2010, at approximately 9:20 a.m., however revealed Resident #1 did not have a training program to address her dental hygiene. There was no evidence the facility ensured the resident's IPP included training in activities of dental hygiene.			1432				
002 1	3523.1 RESIDENT	S RIGHTS		1 500	Cross reference W124		8/23/10	
	that the rights of res protected in accords	ance director shall er idents are observed ance with D.C. Law 2 applicable District and	and -137. this					
	This Statute is not r Based on Interview a falled to ensure the their legal guardian of resident's medical co behavioral status, at and the right to refus residents included in	rights of each resider to be informed of the ondition, development tendant risks of treat se treatment, for one	nt and/or Ital and ment, of three					
	The finding includes:	;						
; ; ;	During the entrance 2010, beginning at a qualified mental retai and Residential Man Resident #2 had sist health care decisions	pproximately 8:30 a.r rdation professional (ager (RM) indicated t er who assisted with	n., the QMRP)					
J	On August 4, 2010, a review of Resident #2	it approximately 12;2 2's medical records re	0 p.m., evealed			}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0083		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
				B. WING _		00,	50/05/0045
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		05/2010
COMMU	NITY MULTI SERVICE		WASHING	STREET NV TON, DC 20	V 9011		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	(XS) COMPLET DATE	
i	Continued From pa a physician's order of mg by mouth one his appointment. Intervisame day approximate the sedation was Review of Resident Assessment dated (4, 2010, at approximate resident was not decisions regarding residential placement #2's record failed to informed consent has of the sedative medial:35 p.m., the QMRI not obtained consent prior to the administration	dated July 2010, for cur prior to her dentriew with the QMRP ately 12:40 p.m. consistive provide 2010, on the nately 1:20 p.m., revit competent to make his health, safety, first. Further review of provide evidence that been obtained for cation. At approxim a acknowledged that the from Resident #2's	e August ealed that at written the use ately	1 500	DEFICIENCY		